Fluid Management in Children

Mikey Bryant

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Fluid management in children

Dr Mikey
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Introduction:

• Fluid management in children is more complex than first appears.
• Very important to know why fluid is being given before giving.
• Be aware of the dangers of over-hydrating patients – pulmonary oedema etc.
• Children need to be treated with caution.
• Constant re-assessment is extremely important to avoid sudden changes in condition.
Starting point: Assessing for shock:

- Shock in a child requires 3 clinical signs:
  - 1. Fast and weak pulse (could also be slow if in severe shock).
  - 2. Cold and clammy peripheries.
  - 3. CRT > 3 seconds.
What is shock?

• Shock: not getting blood carrying glucose and oxygen to important organs

• Organs don’t work well without oxygen and glucose, and can be permanently damaged in shock
  • Heart reduced pumping function
  • Brain lethargy, irritability, coma, convulsion
  • Kidneys stop producing urine
Other helpful fluid management parameters:

• Observe for signs of dehydration – obvious ones such as skin turgor, sunken eyes and lethargy.
• Urine output very important to monitor: this will tell you what is happening earlier than anything else.
• Beware history is not always accurate with a urine output.
• But should be monitored on the ward, forms a part of the history.
Having established shock – 3 questions:

1. Is the child anaemic?
2. Is the child malnourished?
3. Is the child dehydrated?

We are trying to establish a cause for the shock as well as looking at ways to treat.
Assessing Severe Anaemia

- Common
- Often in children with malaria (Malaria parasites destroy red blood cells rapidly)
- Beware children bleeding slowly via GIT.
- Severe pallor
- Low HB
- May cause cardiogenic shock
Management of children with **shock** AND **severe anaemia (Hb<6)**

- Give blood as soon as possible
- No malnutrition: 20 ml/kg over 3-4 hours
- Severe acute malnutrition: 10 ml/kg over 3-4 hours

- Give maintenance fluid while waiting for blood
Giving a blood transfusion

When?  
- Hb < 6 g/dl if child in shock or has signs of heart failure
- Hb < 5 g/dL for all other children

What?  
Whole blood or packed red cells

How much?  
- 20ml/kg whole blood or 10-15ml/kg packed red cells
  - Half of this volume in severely malnourished children

How fast?  
3-4 hrs
Assess for malnutrition:

Look

**Marasmus**
- Old person’s face
- Irritable
- Extreme wasting and low weight

**Kwashiorkor**
- Apathy
- Oedema of legs, arms, face
- Pale, spare hair, weak roots
- Moon face
- Pale, thin, peeling skin
- Hepatomegaly
Assess for dehydration – fluid resuscitation is different
What is your assessment?

- **Normal circulation**: proceed to assess **Disability**

- **Signs of impaired circulation**:
  - 1. Is the child in shock? (ALL of cold hands and feet; CRT >3 secs; weak+rapid pulse)
  - 2. What is the cause of the circulatory problem?
    - Is the child **anaemic**?
    - Does the child have watery diarrhoea, and are they **dehydrated**?
  - 3. Does the child have **severe acute malnutrition**?
### Different causes for shock

<table>
<thead>
<tr>
<th>Cause</th>
<th>Mechanism</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe dehydration</strong></td>
<td>Because of fluid loss through vomiting and diarrhoea or blood loss through bleeding, there is too little blood volume</td>
<td>Hypovolaemic shock</td>
</tr>
<tr>
<td>Severe bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe infection</strong></td>
<td>Infection can damage blood vessels and make them leaky. Fluid leaks out of the vessels into the tissue (oedema) and there is too little fluid left in the blood vessels (too little blood volume). Infection can also damage the heart muscle.</td>
<td>Distributive shock</td>
</tr>
<tr>
<td>bacterial (Septic shock)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>viral (Ebola, Dengue)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe anaemia</strong></td>
<td>Heart failure (too little oxygen in the heart muscle), the heart can’t pump the blood. There are too few red blood cells to deliver oxygen.</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>(Other diseases of the heart)</td>
<td></td>
<td>(weak heart)</td>
</tr>
<tr>
<td><strong>Severe allergic reaction</strong></td>
<td>Severe allergic reactions can also make blood vessels leaky. Fluid leaks into the tissue (oedema), and there is too little fluid left in the blood vessels (too little blood volume)</td>
<td>Anaphylactic shock</td>
</tr>
<tr>
<td>(anaphylaxis)</td>
<td></td>
<td>(leaky vessels)</td>
</tr>
</tbody>
</table>
What would you see if a child is in shock?

- **Airway:** The patient may be unconscious, in which case they are at risk of aspiration and obstruction.
- **Breathing:** The patient may be hypoxic: poor blood supply to lungs to pick up oxygen.
- **Circulation:**
  - The heart beats faster: trying to increase the blood supply to the body.
  - The pulses become weaker.
  - Hands and feet become cold: what level does it stop? Wrist? Elbow?
  - CRT > 3 sec
  - Pale
- **Coma/Convulsion:**
  - Decreased level of consciousness, irritable, convulsion: decreased oxygen and sugar to the brain.
  - Blood sugar might be low.
- **Dehydration**
  - Very severe diarrhoea and dehydration will eventually cause shock.
Shock treatment – cause determined:

• Dehydration – more aggressive fluid management to be discussed later.

• Distributive – boluses as below.

• Cardiogenic – need for blood to improve oxygen to heart.

• Anaphylactic – similar plan to distributive but address the cause with anti-inflammatories.
Treatment of Shock: distributive/anaphylactic

- Cold peripheries AND
- Capillary refill time longer than 3 seconds AND
- Weak and fast pulse

YOU MUST HAVE ALL 3 SIGNS TO BE IN SHOCK.

Child in SHOCK

Shock and NOT malnourished

Hb >6

10 ml/kg over 30 mins
Ringers Lactate or Normal Saline
If shock still present, give further 10 ml/kg over 30 minutes; can repeat again if needed

Hb <6

If Hb < 6 transfuse whole blood
20 ml/kg
Over 4 hours

Shock AND malnourished

Hb >6

10 ml/kg over 1 hour
Ringers Lactate with 5% Dextrose or Normal Saline with 5% Dextrose

10 ml/kg
Over 4 hours
Shock and NOT Malnourished with Hb >6

- Bolus: 10mls/kg over 30 mins
- Fluid: RL or NS
- Reassess after each bolus
- Can be repeated 2x if shock not resolved
Shock and Malnourished with Hb >6

- Bolus: 10mls/kg over 1 hour
- Fluid: RL+D5 or NS+D5
- Reassess after the bolus
- The bolus should not be repeated
After the initial treatment of Shock

<table>
<thead>
<tr>
<th>NO MALNUTRITION</th>
<th>SEVERE MALNUTRITION</th>
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</thead>
<tbody>
<tr>
<td>If shock not secondary to diarrhoea:</td>
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</tr>
<tr>
<td>SHOCK RESOLVED: Give maintenance fluids or feeds following the protocol below</td>
<td>SHOCK RESOLVED: Start NG/oral ReSoMal following Step 2 for malnourished children</td>
</tr>
<tr>
<td>SHOCK PERSISTS: Give maintenance fluids AND Consider blood transfusion</td>
<td>SHOCK PERSISTS: Start NG/oral ReSoMal following Step 2 for malnourished children AND Consider blood transfusion</td>
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SHOCK SECONDARY TO DIARRHOEA

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<tr>
<th>NO MALNUTRITION</th>
<th>SEVERE MALNUTRITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO MALNUTRITION: Follow Severe Dehydration Step 2</td>
<td>SEVERE MALNUTRITION: Start NG/oral ReSoMal following Step 2 for malnourished children</td>
</tr>
</tbody>
</table>
After the initial treatment:
Shock not secondary to dehydration

• Child not malnourished:

  Shock resolved:
  • Give IV maintenance fluid or NG/PO feeds

  • Shock not resolved:
  • Give maintenance fluid
  • AND
  • Consider blood transfusion
After the initial treatment:
Shock not secondary to dehydration

- Child Malnourished

- **Shock resolved:**
  - Give NG/PO ReSoMal following step 2 for the child with SAM

- **Shock not resolved:**
  - Give NG/PO ReSoMal following step 2 for the child with SAM
  - **AND**
  - Consider blood transfusion
What is IO cannulation?

Inserting a line into the marrow cavity providing access to non-collapsible venous plexus
Site

• Sternum
• Humerus
• Femur
• Tibia- proximal and distal
• Ilium
Tibia

- Proximal or distal
Types of IO
Contraindications

• Distal trauma (fracture on the same side)
• Infection
• Previous attempt on the same site
• Osteogenesis imperfecta
• Bleeding problems (relative contraindication)
Reason for failure

- Incorrect identification of landmarks
- A bent needle
- Clogging of the needle with marrow
- Through-and-through penetration of both anterior and posterior cortices
- Fractures caused by excess force or by fragile bones
- Penetration of the mediastinal structures or space with the potential for pneumothorax, vascular injury, lung injury, in the case of a sternal needle
Complications

- Local infection
- Compartment syndrome secondary to fluid extravasation
- Local hematoma
- Pain
- Potential for growth plate
- Fat embolus
- Bone embolus (though this has not been reported in humans)
- Mediastinitis after sternal IO puncture
Watery Diarrhoea

• In small children, diarrhoea is usually caused by viruses, and not by bacteria

• These viruses are highly infectious, and easily spread between people
Watery Diarrhoea

- Diarrhoea (frequent watery stool)
- Vomiting (not always)
- Might be unable to drink
- Low grade fever

Treatment:
- **Rehydration** (PO, NG or IV)
- Zinc
- Advise to feed continuously
- **ANTIBIOTICS ONLY IF BLOODY DIARRHOEA**
How to assess dehydration

Look; Feel: signs of dehydration

- Sunken Fontanelle
- Sunken Eyes and Cheeks
- Few or No Tears
- Decreased Skin Turgor
- Dry Mouth or Tongue
- Sunken Abdomen
Skin pinch
Grades of Dehydration

- **No Dehydration** (no signs of dehydration)
- **Some Dehydration**
- **Severe Dehydration**
Emergency signs for severe dehydration

• Watery diarrhoea and
• 2 out of the 4: Lethargy
  Sunken eyes
  Very slow skin pinch
  Unable to drink
Child with **Severe** dehydration

**Dehydrated and NOT malnourished**
- **Ringer’s Lactate, Normal Saline**
  - *Use DNS for dehydration only if RL or NS is not available*
  - **INFANTS (under 1 year)**
    - Step 1: 30ml/kg in the first hour
    - Step 2: 70ml/kg in the next 5 hours
  - **CHILDREN (over 1 year)**
    - Step 1: 30 ml/kg in the first 30min
    - Step 2: 70 ml/kg in the next 2.5 hours

**Dehydrated AND malnourished**
- **ReSoMal oral**
  - Step 1: 5ml/kg every 30 minutes for the first 2 hours
  - Step 2: 5 to 10 ml/kg every hour for the next 4 to 10 hours. If possible, alternate F75, 5 mls/kg, with ReSoMal
  - *If child unable to tolerate oral or NG fluids, consider careful IV rehydration with RL+D5*
Severe Dehydration

Dehydrated and NOT malnourished

Ringer’s Lactate, Normal Saline
Use DNS for dehydration only if RL or NS is not available

INFANTS (under 1 year)
Step 1: 30 ml/kg in the first hour
Step 2: 70 ml/kg in the next 5 hours

CHILDREN (over 1 year)
Step 1: 30 ml/kg in the first 30 min
Step 2: 70 ml/kg in the next 2.5 hours
Treatment of severe dehydration (not in shock) in malnourished children

• Signs of dehydration are difficult to assess in malnourished children
• The heart muscle is weak and wasted, so giving IV fluids in large amounts is dangerous
• Oral rehydration with ReSoMal:
  • 5 ml/kg for every 30min for the first 2 hours
  • 5-10 ml/kg per hour for the next 4 to 10 hours (in between F75, every 2 hours
• Every child with SAM and diarrhoea should receive ReSoMal (treatment or prevention of dehydration)
Dehydrated AND malnourished

ReSoMal oral
- Step 1: 5ml/kg every 30 minutes for the first 2 hours
- Step 2: 5 to 10 ml/kg every hour for the next 4 to 10 hours. If possible, alternate F75, 5 mls/kg, with ReSoMal

*If child unable to tolerate oral or NG fluids, consider careful IV rehydration with RL+D5*
Dehydration

Watery diarrhoea + 2 of the following:

SEVERE
- Sunken eyes
- Lethargic
- Very slow skin pinch (>2 sec)
- Unable to drink

SOME
- Sunken eyes
- Restless
- Slow skin pinch (<2 sec)
- Thirsty
WATERY DIARRHOEA + 2 out of the 4:
- Restless, irritable
- Sunken eyes
- Slow skin pinch (< 2 seconds)
- Thirsty/drinks eagerly

If child not in shock but has some dehydration:

Child with SOME dehydration

Dehydrated and NOT malnourished
- ORS 75mls/kg over 4 hours
  - More can be given is the child wants more
  - The child can continue breast feeding
  - If the child becomes puffy stop ORS and encourage breastfeeding
- All children over 6 months should be given some food before discharge

Dehydrated AND malnourished
- ReSoMal oral
  - Step 1: 5ml/kg every 30 minutes for the first 2 hours
  - Step 2: 5 to 10 ml/kg every hour for the next 4 to 10 hours. If possible, alternate F75, 5 ml/kg, with ReSoMal
- If child unable to tolerate oral or NG fluids, consider careful IV rehydration with RL+D5
Dehydrated and **NOT** malnourished

- ORS 75mls/kg over 4 hours
  - More can be given if the child wants more
  - The child can continue breastfeeding
  - If the child becomes puffy stop ORS and encourage breastfeeding

All children over 6 months should be given some food before discharge
Some Dehydration in malnourished children

Dehydrated AND malnourished

ReSoMal oral

- Step 1: 5ml/kg every 30 minutes for the first 2 hours
- Step 2: 5 to 10 ml/kg every hour for the next 4 to 10 hours. If possible, alternate F75, 5 mls/kg, with ReSoMal

If child unable to tolerate oral or NG fluids, consider careful IV rehydration with RL+D5
## Fluid management: summary

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<tr>
<th>Condition</th>
<th>Not malnourished</th>
<th>Malnourished</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock (all 3 features)</td>
<td><strong>IV</strong> 10-20mls/kg RL/NS over 1 hour (10mls/kg over 30mins can be repeated 2x)</td>
<td><strong>IV</strong> RL+D5% 10-15mls/kg over 1hr</td>
</tr>
<tr>
<td>Severe dehydration</td>
<td><strong>IV</strong> 30mls/kg RL/NS/DNS: &lt; 1yr over 1 hr, &gt;1yr over 30mins 70mls/kg RL/NS/DNS : &lt; 1yr over 5 hrs, &gt;1yr over 2.5hrs</td>
<td><strong>PO/NG</strong> ReSoMal 5mls/kg every 30min</td>
</tr>
<tr>
<td>Some dehydration</td>
<td><strong>PO/NG</strong> ORS 75mls/kg over 4 hours</td>
<td><strong>PO/NG</strong> ReSoMal 5mls/kg every 30min</td>
</tr>
<tr>
<td>Impaired circulation (some but &lt;3 features of shock)</td>
<td><strong>IV</strong> Maintenance</td>
<td><strong>PO/NG</strong> ReSoMal 5mls/kg every 30min</td>
</tr>
</tbody>
</table>
Maintenance Fluid and Feeds

Which children need maintenance fluid?

• Any child who is nil by mouth (NPO):
  • Severe respiratory distress
  • Bowel obstruction (perforation, septic ileus....)
  • AVPU and at high risk of aspiration

• Well nourished children with impaired circulation (some, but not all 3 features of shock)
What fluid to give?

- Most children should receive fluid containing dextrose
- Normally Dextrose Normal Saline (DNS)
- or
- Ringer Lactate with 5% Dextrose

- For short periods, it is possible to use Ringer’s Lactate: make sure to check the blood glucose level!
- **YOU MUST NEVER GIVE ONLY D5%**
How much fluid to give?

• In order to calculate the child’s IV maintenance fluids over 24 hours:

  • Use the weight of the child
  • 1\textsuperscript{st} 10 kg: 100 ml/kg
  • 2\textsuperscript{nd} 10 kg: 50 ml/kg
  • Any further kg: 25 ml/kg
Calculating how much fluid/feed to give over 24 hours

• 12kg child:
  
• 10kg x 100ml = 1000ml
  
• 2kg x 50ml = 100ml
  
• Total over 24 hours = 1100ml
Calculating how much fluid/feed to give over 24 hours

• 24kg child

• 10kg x 100ml = 1000ml

• 10kg x 50ml = 500ml

• 4kg x 25ml = 100ml

• Total over 24 hours = 1600ml
Calculating 3 hourly feeds

• 24kg child: 1600ml in 24 hours
• 3 hourly feeds = 8 feeds in 24 hours
• 1600/8 feeds = 200ml per feed
Hypoglycaemia:

• Ideally less than 70 mg/dl should be treated.
• Avoid further hypoglycaemic events by managing fluids and feeds effectively.
• Consider hypoglycaemia to be a sign of either malnutrition, sepsis or another serious underlying condition.

• Treat with D10% 5mls per kg.
Summary

• Fluid loss from diarrhoeal disease can kill if the fluid is not replaced
• It is important to make a careful assessment of the degree of dehydration, using the most reliable signs
• Severe dehydration is an emergency sign, and requires immediate action
• Treatment will differ, depending on whether or not the child is malnourished
• It is important to make a plan for the child’s ongoing fluid requirements, and to calculate and prescribe the fluids for the first 24 hours of admission